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AUTHOR	Atkins, Marc; Collins, Kari; Devine-Johnston, Laura; Eber, Lucille; Pacchiano, Debra; Palmer, Teri; Robbins, Vestena
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ABSTRACT

Summaries of four papers and a discussion presented at a symposium on expanding the research base of systems of care for children's mental health examine school-wide systems of positive behavioral support and provide data on a three-tiered Positive Behavior Intervention and Support (PBIS) program for improving mental health functioning of students. Supported by federal initiatives, the papers provide examples of the connections between a systematic data-based decision-making approach and the use of effective practices among school personnel. First, "Building School Capacity To Support All Students through School-wide Positive Behavior Systems" (Lucille Eber and Teri Palmer) describes PBIS implementation in 35 Illinois schools. Second, "A School-Based Wraparound Example: Outcomes and Processes" (Debra Pacchiano and others) presents outcome data for a youth and family with intensive medical, academic, and behavioral needs. Third, "Behavior Support Plans for Students with or At-risk of Emotional/Behavioral Challenges" (Vestena Robbins and others) analyzes 12 Behavior Support Plans developed by a centralized Behavior Intervention Team in a suburban Chicago school district. Finally, "Building Bridges of Support in Eastern Kentucky: Outcomes of Students Receiving School-Based Wraparound" (Vestena Robbins and Kari Collins) highlights program features and describes characteristics and outcomes of children and families (n=324) in a rural Appalachian area. (Individual paper summaries contain references.) (DB)

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School-Wide Systems of Positive Behavioral Support: Promoting the Mental Health of all Students, Including those with SED

By
Lucille Eber
Debra Pacchiano
Vestena Robbins

2003

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Symposium

School-wide Systems of Positive Behavioral Support: Promoting the Mental Health of all Students, Including Those with SED

Chair
Lucille Eber

Discussant
Marc Atkins

Authors
Lucille Eber et al.
Debra Pacchiano et al.
Vestena Robbins et al.

Symposium Introduction

Lucille Eber

A school-wide system of Positive Behavior Interventions and Supports (PBIS) employs data-based decision-making to foster school environments that promote pro-social behavior of students. The papers presented here provide data on a three-tiered PBIS approach to improving mental health functioning of all students in schools, including those with SED. These papers provide examples of the connections between a systemic, data-based decision-making approach and the use of effective practices among school personnel. Supported by federal initiatives from both education and mental health, the research findings that follow include data from the ongoing evaluation of primary, secondary, and tertiary school-based systems of prevention and intervention in Illinois and Kentucky.

Building School Capacity to Support All Students through School-wide Positive Behavior Systems

Lucille Eber & Teri Palmer

Introduction

Positive Behavioral Interventions and Supports (PBIS) is a systems approach focused on building the capacity of schools to teach and support positive behavior of all students by developing research-based, school-wide and classroom discipline systems. Rather than a prescribed program, PBIS provides a process for schools to design, implement, and evaluate their own effective school-wide, classroom, and student-specific discipline plans. PBIS includes school-wide procedures and processes intended for: (a) all students, staff, and school settings; (b) non-classroom settings within the school environment; (c) individual classrooms and teachers, and; (d) individual student support for the students who present the most challenging behaviors (Sugai & Horner, 1999; Sugai, Sprague, Horner, Walker, 2000).

Illinois' PBIS Initiative

Building on a history of successful implementation of system of care (SOC) and wraparound approaches (Eber, Rolf, & Schreiber, 1996), Illinois is a demonstration site for the National PBIS Center. Sponsored by the Illinois State Board of Education, the Illinois' Emotional and Behavioral Disturbance (EBD) Network provides leadership and support for wraparound through schools, and has partnered with safe school initiatives in Illinois to implement positive school-wide discipline systems. Staff from over 200 schools have received training in PBIS, and the PBIS approach has been implemented in their schools. In addition, over 75 site-based coaches have been identified and trained, with support from the Office of Special Education Programs' (OSEP) National PBIS Center. These coaches are supporting implementation and evaluation of PBIS in Illinois schools. This PBIS focus is intended to complement and support the existing interagency and school-based wraparound efforts by creating more effective host environments for implementing strength-based interventions around those with or at-risk of EBD while also preventing the development of behavior problems in many students (Eber, Sugai, Smith & Scott, 2002).

This paper describes the evaluation method and results that are specific to the universal (school-wide) level of the PBIS system, including: (a) strategies for establishing research-based practices and

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data-based evaluation systems in schools, (b) methodology and initial findings of the effect of school-wide systems, and; (c) implications for enhancing system-of care-approaches for students with EBD and their families.

Methodology

Because educators actively use data to make decisions throughout implementation, evaluation strategies are a critical element of PBIS. School teams and coaches use quarterly checklists to monitor and guide their actions, providing internal and external checks on implementation progress. The School-wide Evaluation (SET) Survey is completed by outside reviewers who observe the status of seven critical features of school-wide PBIS systems in schools. Additionally, schools review and analyze their existing school-based data systems, including office discipline referrals (ODR), in-school suspensions (ISS), out of school suspensions (OSS), attendance, and tardiness. Leadership teams at each school site are instructed in how to use these data to guide decision-making about design and evaluation of research-based behavior strategies aimed at reducing rates of undesirable behaviors. Teams are taught to guide their schools in using effective instructional strategies around replacement behaviors, high levels of reinforcement for competing behaviors, and clear, consistent adult responses to incidents of misbehavior.

Also included in this paper are data from school profiles that provide demographic and student behavior data. The profiles include the numbers and types of interventions implemented school-wide, the estimated level of staff participation and the estimated level of impact by PBIS in the schools. In June 2000, 14 schools voluntarily completed these end-of-year profiles. In June 2001, 35 schools completed profiles, although student behavior data were not available for all schools.

Results/Discussion

Results of the PBIS process include an increase in proactive behavioral strategies among school staff, reductions in office discipline referrals, in-school suspensions, and out of school suspensions. A combination of process and outcome measures provide information to guide sustainability efforts in Illinois schools. For example, two-year SET and checklist data suggest that schools, with active coaching, progress at a slightly higher rate toward implementation of critical features of PBIS at the school-wide level. Additionally, these schools have maintained scores in the sustainability range (80% or higher), while initiating more individualized interventions for students with significant challenges, including those with SED. Data also suggest that lowered rates of suspensions and office discipline referrals were sustained while schools moved forward with building their capacity for specialized interventions with identified students.

Although the results reported by the 35 schools that completed profiles are not necessarily reflective of the total schools participating in the larger project, these schools have demographic data similar to the demographics of the total number of schools implementing PBIS in Illinois. Results provided by the 35 schools show a comparable sample of the range and diversity of participating schools; they include 20 elementary, 6 middle, 4 high school and 5 combined grades (2 elementary/middle, 3 middle/high). Twenty-two schools (63%) were urban, 4 schools (11%) were suburban, and 9 (22%) were rural. Average free and reduced lunch was available for 42 % (range 0-87%) of students, and 35% (range 0-80%) of students were members of an ethnic/minority group. All geographic regions of the state were represented in the sample.

As a measure of the use of effective behavior practices, teams were asked to report the number and type of interventions implemented along the continuum of support. A total of 118 interventions were reported across the 35 schools as follows:

- 66% of the schools implemented school-wide strategies, affecting 80-90% of students.
- 20% of schools utilized targeted group strategies, affecting 5-15% of students.

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- 11% of schools used targeted individual strategies, affecting 1-15% of students.
- 3% of schools employed intensive-wraparound strategies, affecting 1-5% of students.

These data represent an increase in the number of schools reporting the use of individualized interventions for students with higher behavioral needs, including those with SED.

Teams were asked to estimate the level of staff participation with the different interventions. Across the interventions, staff participation was rated as at least 80% for 66% of the interventions (46% at 90-100%, and 20% at 80-90%). The majority of interventions in which less than half of the school staff participated were for targeted and wraparound-based interventions; this indicates that schools are allocating staff resources appropriately within their continuum. Teams were also asked to estimate the level of impact achieved by the interventions. Ninety-two percent of the interventions were rated as having a Medium to Very High impact; of this figure, 77% of the interventions were for students with significant challenges.

Data from individual schools have been summarized into one-page profiles that describe the interventions designed and evaluated by each school. These school-specific summaries include changes in student behavior data, and strategies adopted by the schools that illustrate how schools are using data to guide decision-making about changing student and staff behavior. The information reported by school PBIS teams suggests these schools are using their existing data to improve their interventions and are developing system approaches for designing proactive interventions for students who require more targeted and intensive interventions. Examples of data and strategies from these individual summaries are described below.

A rural elementary school experienced a 52% reduction in ODRs. When compared to the number of ODRs experienced in their pre-PBIS school year, this school has successfully reduced ODRs by 61% in two years, dropping from 250 to 97. Continuing success at the school-wide level with 80-90% of students encouraged the faculty to introduce a targeted group intervention and several intensive/ school-based wraparound interventions for some students with significant behavioral and emotional challenges

An urban elementary school reported a 42% reduction in ODRs and a 50% reduction in OSSs at the end of its second year as a PBIS school. During Year 2, the school designed two targeted group interventions for students who were continuing to struggle behaviorally. The first intervention was peer mediation, in which fourth and fifth grade students were trained as peer mediators. Faculty report that this targeted intervention has had a High impact on the behavior of 80-90% of the participating students. The second targeted intervention, "Team Superstars," involves a group of students who need extra support, according to behavioral data. On a weekly basis, they meet in groups after-school and engage in fun activities that promote goal-setting, team work, and social interaction skills.[1]

Discussion

Strength-based, multiple-life domain interventions are recommended for students with significant EBD. However these types of approaches are time-consuming and difficult for teachers and school staff to implement; this is especially the case if educators are frustrated by behavior problems among high numbers of students in the school. Results in Illinois schools suggest that improving systems that support behavior at the universal level (e.g. school-wide for the 80-90% of students) can lead school teams to establishing systems for effective interventions for students with more intensive and chronic, emotional and behavioral problems. Strategies for sustaining these universal changes in schools are encouraging and can prevent new cases of problem behavior from developing. Also, educators are able to direct more time and resources to students with more significant needs. School staff are learning

[1] *Individual profiles for participating schools are available in the PBIS section of the Illinois website: www.ebdnetwork-il.org*

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how to engage families, community agencies, and natural support persons into teams that can design effective behavior change strategies for students. These child/family teams are being guided to use data (i.e. functional assessments, information gained from conversations with families) to design individualized, strength-based interventions across home, school, and community. Data collection around these students and their families are being collected and analyzed to determine the that effect school-wide PBIS approaches can have on students with more intensive needs (e.g., those with EBD) over time. While the data suggest that these schools can be encouraged to use data to guide interventions that improve student behavior, it is important to note that these results are not representative of change across all participating schools.

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A School-Based Wraparound Example: Outcomes and Processes

Debra Pacchiano, Lucille Eber, & Laura Devine-Johnston

Introduction

School-based wraparound is a strengths-based process through which intensive, individualized supports are designed, implemented, and monitored for children, youth, and families with significant emotional and behavioral needs. Facilitated by school-based staff, the process begins by identifying the perspectives and goals of the family and the school, then blending these perspectives to prioritize action planning across life domains. Action plan strategies build on family and school strengths, in combination with function-based positive behavioral interventions. This paper presents outcome data from a school-based wraparound initiated for a youth and family with intensive medical, academic, and behavioral needs. Data were collected at baseline, four, nine, and 12 months.

Background

Schools and school-based clinical staff continue to build their capacity to prevent and meet the emotional and behavioral needs of all students, including those with the most significant challenges. One approach to building school-based capacity with prevention and intervention are school-wide models of behavioral support, specifically Positive Behavioral Interventions and Supports (PBIS; Sugai & Horner, 1999). PBIS creates or restructures three specific systems of behavioral support within school buildings that support staff to implement research-based effective practices with all students. These three systems include the following: the universal school-wide system; the targeted intervention system; and the intensive intervention system. The intensive system is designed to support the approximately 1-7% of the student population in a school building who require the most specialized and individualized social-emotional-behavioral supports.

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The Illinois State Board of Education currently funds a statewide PBIS initiative to train and support schools to design and implement PBIS in their buildings. As PBIS schools begin developing their intensive system of behavioral support, training is provided for a school-based wraparound process (Eber, Sugai, Smith & Scott, 2002), along with on-going technical assistance as staff implement the process with children and youth with intensive needs. During the 2000/01 school years, a school district implementing PBIS in Illinois began piloting the process of school-based wraparound as one component of their intensive system of behavioral support. The outcome data for this paper reflects one of their pilot school-based wraparound processes.

A school-based wraparound process was initiated in November, 2000 and continued through the 2001-02 school year with a 13-year-old male freshman and his single mother. The youth has a diagnosed chronic medical condition requiring daily monitoring, decisions about appropriate medical management, and implementation of those decisions. At the time the school-based wraparound was initiated, baseline rates of the youth's attendance, classwork and homework completion, tests/quizzes/grades, medical status across home and school, social connectedness, and aggressive behavior incidents in the home indicated the need for intensive, individualized interventions and supports. In response, school administrators began pursuing a change of the youth's special education placement to a highly restrictive self-contained special education school outside of the youth and family's neighborhood. Family and school relations had deteriorated; interactions and other communications were mostly of an adversarial nature.

Methodology

Baseline and outcome data were collected at four, nine, and twelve months using four evaluation instruments: Educational Information Form, Youth and Family Checklist, Parent and Youth Satisfaction Survey, and the Collaborative Team Planning Form (CTPF). The Educational Information Form organizes teacher input regarding educational placement, classroom functioning, need for academic and behavioral supports, and academic performance. The Youth and Family Checklist organizes family perceptions of youth needs and strengths in the areas of safety/medical/basic needs, social relationships, emotional functioning, behavioral functioning, cultural/spiritual, and at-risk behaviors across home, school, and community. The CTPF organizes action planning and ongoing monitoring of progress toward family and school identified goals. Additional outcome data were collected on the youth's medical management and status.

Results

Outcome data reflect positive changes in the youth and family functioning across life domains from baseline to four months; however, maintenance of these changes was not demonstrated in the outcome data from four months to nine months. However, a new teacher/case manager was assigned to the youth at nine months, and at 12 months improvements were shown in specific areas. Tables 1 and 2 show outcome data from the Educational Information Form and the Youth and Family Checklist, respectively.

The Parent and Youth Satisfaction Survey is a Likert Scale from 1 (*not at all*), to 4 (*a great deal*). The percentage of items rated *a great deal* by the parent was 100% at four months. This figure dropped to 50% at nine months, and increased to 88% at 12 months. The percentage of items rated *a great deal* by the youth were 70% at four months, decreased to 60% at nine months, and reached 80% at 12 months.

Results of the Collaborative Team Planning Form indicated that action planning had "Resolved or attained to satisfaction of family & teacher" 50% of the time at four months, 35% at nine months, and 42% at 12 months. The percentage of action planning items rated as "Progress made but still a need" was 44% at four months, and 55% at nine and twelve months. The percentage of items rated "Unresolved or worse" went from 1% at four months to 10% and 3% at nine and twelve months, respectively.

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Table 1
Educational Information Form:
Outcome Data for One youth at Baseline, 4, 9, and 12 Months

Domain	*Baseline*	*4 Months*	*9 Months**	*12 Months*
Teacher's knowledge of student	Moderately well	Very well	Not well	Very well
Special education service delivery	< 50% of the day	General classroom & special ed consultation	< 50% of the day	General classroom & special ed consultation
Classroom functioning *(Likert-type scale 1- never, 4- always, 4 indicates youth strengths)*	15% of items rated a 4	77% of items rated a 4	7% of items rated a 4	62% of items rated a 4
Extra academic assistance needed	No	No	Yes	Yes
Extra behavioral interventions needed	Yes	Yes	No	Yes
Academic performance	Average	Above average	Below average	Average

* New teacher/case manager assigned

Table 2
Youth and Family Checklist: Percentage of Items Rated
High/Somewhat Need or High/Somewhat Strength

Setting	*Need or Strength*	*Baseline*	*4 Months*	*9 Months**	*12 Months*
Home	Need	47%	21%	44%	35%
Home	Strength	53%	79%	46%	75%
School	Need	56%	15%	47%	38%
School	Strength	44%	85%	45%	62%
Community	Need	32%	21%	21%	6%
Community	Strength	68%	76%	79%	94%

* New teacher/case manager assigned

Discussion

This case study illustrates a school's early experiences with the wraparound process for one youth, and the need to consistently and proactively apply the process, not only to achieve positive change, but to sustain change over time. Four months into the wraparound process, the family (i.e. parent and student) indicated high levels of satisfaction, which indicated a significant shift from their reports of previous experiences with school meetings. Initially, the family and school team focused on reaching consensus about a medical management plan, the major source of ongoing disagreement and blame between school and family. As family and school relationships improved, the student's academic and behavioral functioning improved as well. However, when the new school year began four months later, and a new teacher/case manager at school was assigned, the team reconvened immediately but did not emphasize the clarification of roles, responsibilities and tasks among team members. Although behavioral functioning remained stable, academic performance and family satisfaction decreased—in some cases, back down to baseline rates—indicating a need to refocus team consensus for problem-solving on these issues.

At 12 months into the wraparound process, the child and Family team had re-established a consistent meeting schedule and positive rapport between the case manager, youth, and the parent. Family satisfaction levels returned to high levels and the youth's behavioral and academic functioning

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improved, from nine month status to only slightly below four month status. Results suggest that the school-based wraparound process can make significant improvements in family and school partnerships and student functioning, both behaviorally and academically. However, the wraparound process must be consistently applied over time. Careful attention must be given to changes in school schedules (i.e., summer vacation followed by new teachers and class schedules) in order to avoid disruption in the youth's progress and to maintain training and support for school-based team members who are new to the process of wraparound.

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Behavior Support Plans for Students with or At-risk of Emotional/Behavioral Challenges

Vestena Robbins, Lucille Eber, & Laura Devine-Johnston

Introduction

Challenging behavior and discipline issues are top concerns among both educators and others who work with students with emotional and behavioral problems. Despite a lack of evidence supporting their effectiveness, educators routinely rely upon punitive approaches to discipline such as seclusion and exclusion, rarely achieving the desired outcome of decreased problem behavior. The need for more effective discipline approaches is apparent. Positive Behavior Interventions and Supports (PBIS) is a systems approach intended to assist schools in organizing effective behavioral practices and data-based decision making around all students (Sugai & Horner, 1999). PBIS establishes three specific levels of behavioral support within school buildings that support staff to implement research-based effective practices with all students. These three systems include the following: the Universal School-Wide System, the Targeted Intervention System, and the Intensive Intervention System.

The development, implementation, and monitoring of positive behavior support plans is a critical feature of a school-wide system of PBIS for students who are at-risk of developing chronic behavior problems. These students (typically 5-15% of the school population) require targeted interventions specific to their behavioral needs. Additionally, students who have chronic and intensive behavioral needs (1-7% of the school population) that are often evident at home, school, and in the community also require behavior support plans in combination with other supports and services. Behavior support plans are often integrated into Individualized Education Plans (IEPs) and/or wraparound plans for these students (Eber, Sugai, Smith & Scott, 2002).

Building capacity within schools for efficient and effective behavior support planning at the first sign of problem behavior is a critical feature of PBIS. Indian Prairie School District in suburban Chicago has had a centralized Behavior Intervention Team (BIT) for the past seven years. This team of four trained behavior specialists has assisted the 28 schools in this district with function-based behavior support plans, mostly around students with chronic and intensive behavior problems, and usually in conjunction with Special Education programming. Illinois' PBIS Initiative has assisted the district in implementing the universal (school-wide) level of PBIS over the past three years. As part of PBIS implementation, the BIT began teaching school-based Action Teams to use function-based behavior support planning for students at-risk (5-15%) rather than waiting for problem behavior to increase in severity before requesting assistance from the BIT. Approximately seven schools have had a full year of experience with developing behavior support plans through building-based Action Teams.

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Methodology

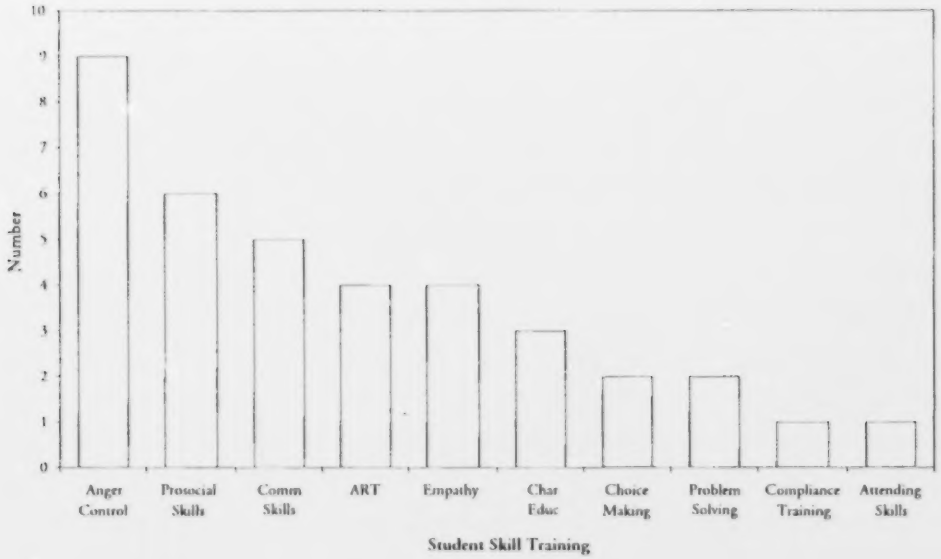
A sample of Behavior Support Plans (N = 12) developed by the centralized BIT and building-based Action Teams were systematically reviewed to determine team configuration, referral patterns, and the nature and scope of interventions and supports included in the plans. Plans were examined at an aggregate level to evaluate team performance in the development of plans and to assist with ongoing program improvement, practice refinement, and staff development needs.

Results/Discussion

The average number of team members involved in plan development was six. With respect to team configuration, members included teachers, district BIT members, administrators, paraprofessionals, student support staff (e.g., social workers, school psychologists) and parents. Students and peers may also participate on teams; however, this was not the case for this sample of plans. Students within this sample were referred from the following grade levels: primary (n = 6), intermediate (n = 5), and high school (n = 1). Most students were referred for multiple problems, with the most common being noncompliance (n = 9) and problems controlling anger or modulating emotions (n = 6). These findings may indicate a need to target these areas for district-wide staff development and training, particularly for general educators. For this sample of plans, most skill building strategies focused on students and included such areas as anger control training, prosocial skill development, communication skills, and aggression replacement training (see Figure 1).

Some plans also included skill training for staff (n = 4) in areas such as assistive technology, communication overlay, and de-escalation strategies. In addition to interventions, plans also included educational strategies and supports (n = 7), such as one-on-one instruction, goal setting, and case management. Supports, such as case management or social work, are essential components of plans because they address factors beyond the immediate context in which the behavior of concern occurs.

Figure 1
Skill Training/Educational Strategies
(N = 12 BSPs)



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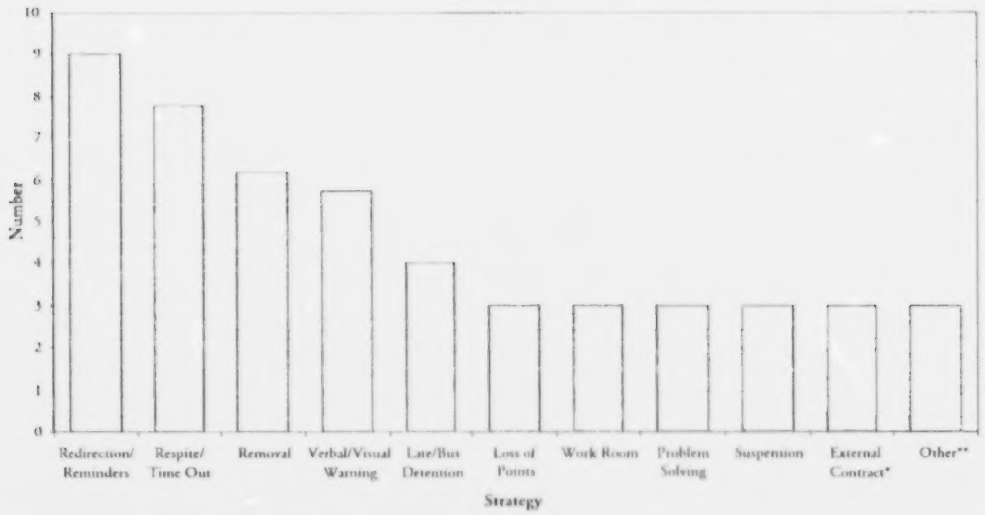
Plans identified both positive and reactive consequence strategies. With respect to positive consequence strategies, encouragement/praise was the most commonly used (n = 13). Other positive strategies included the use of a point system/token economy (n = 6), earning free time/breaks (n = 6), the use of reinforcers/rewards (n = 4), allowing students to engage in special activities (n = 3), humor (n = 2), and the use of active problem solving (n = 2). An array of reactive strategies was included in the plans; however, a pattern emerged in that the most intrusive types (e.g., suspension) were used the least, while less intrusive strategies (e.g., redirection) were the most common (see Figure 2).

Figure 2
Reactive Consequence Strategies
(N = 12 BSPs)



*External contact with parent, truent officer, police
**Other includes de-escalation with adult support and letter of apology

Each plan also included crisis response strategies. For example, parent (n = 8) and administrative contact (n = 7) were common crisis strategies. While teams relied upon a variety of methods to evaluate and monitor plan progress, the most frequently used method was daily behavior/point sheets (n = 8). Some plans required the use of anecdotal records and incident logs (n = 2), monitoring detentions/referrals (n = 1), and reviewing grades (n = 1). Teams met either monthly or quarterly to review plan progress and implementation.

The reviews of these plans indicate that behavior intervention teams may wish to consider the following additions to their process: (a) the incorporation of a self-assessment process (e.g., checklist) to ensure that essential elements of an effective behavior support plan are included (see, for example, Horner, Sugai, Todd, & Lewis-Palmer, 1999-2000); (b) mechanisms to monitor the fidelity of plan implementation by describing each component of the plan and the person responsible. Monitoring fidelity every three to five days is recommended; and (c) to evaluate the impact of the plan by conducting progress checks at least every two to three days and revise the plan as needed.

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Building Bridges of Support in Eastern Kentucky: Outcomes of Students Receiving School-Based Wraparound

Vestena Robbins & Kari Collins

Introduction

Upon receipt of a Center for Mental Health Services (CMHS) grant in 1998, a school mental health initiative was implemented in 21 schools in the Appalachian Mountains of Kentucky. Termed the Bridges Project, this collaborative model focuses on promoting partnerships among families, educators, and service providers to better meet the needs of students with emotional and behavioral disabilities and their families. The purpose of the project is to build upon and enhance Kentucky's existing system of care in three rural Appalachian mental health regions in eastern Kentucky. This area of the state possesses characteristics that differ dramatically from the rest of the state, such as high rates of poverty, unemployment, and illiteracy. Due to the rural nature of the region, lack of transportation, limited community services and resources, and a shortage of human services professionals serve as barriers to effective service delivery. Despite these barriers, the Bridges Project seeks to provide services in a way that acknowledges and builds upon the strengths of the Appalachian culture.

Adequately addressing the needs of children and youth with emotional and behavioral disabilities often requires the involvement and support of multiple child-serving agencies in collaboration with families. However, a 5-year evaluation of the Kentucky IMPACT Program (Illback, Birkby, & Sanders, 1996) revealed limited coordination and integration between education and other child-serving agencies. Acknowledging schools as a critical partner in system of care efforts and the challenges and opportunities underlying their effective inclusion, the primary feature of the project centers upon developing and evaluating a school mental health service delivery model designed to promote and support the mental health needs of all students in the school through the provision of universal, targeted, and intensive interventions and supports. In this model, school-based student service teams (SSTs), consisting of a service coordinator, family liaison, and an intervention specialist, are employed by community mental health centers but located within schools ($N = 21$). In addition, a behavior consultant is assigned to each region. In collaboration with school staff, the SST and behavior consultant facilitate the implementation of a continuum of positive behavior supports (Sugai & Horner, 1999).

This paper highlights program features and describes the characteristics and outcomes of children and families ($N = 324$) participating in a school-based wraparound process. One-year outcome data, service delivery patterns, and satisfaction ratings are presented. Given the school-based nature of the program, particular consideration is given to the examination of educational functioning over time. Policy, program, and practice implications are discussed.

Methodology

As part of the national evaluation process of CMHS-funded grant communities, descriptive, outcome, and intervention-level data are gathered for children and families receiving wraparound

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through the Bridges Project. Upon referral and acceptance to the Bridges Project, the caregiver completes an intake process in which demographic information, risk factors, family composition, problem history, and service history are gathered. If consent is obtained, SSTs conduct an intensive structured interview with the caregiver and/or youth at baseline and every six months thereafter. Data from this interview yield information regarding the child's living situation, academic and behavioral functioning, behavioral and emotional strengths, as well as family resources and degree of strain. In addition, service delivery and satisfaction data are gathered. Local evaluation efforts have focused on gathering teacher-reported information on school performance, including both academic and behavioral functioning.

Results

Descriptive Information for Youth and Families (N = 324) Receiving School-Based Wraparound

Consistent with previous literature on the characteristics of youth with serious emotional disabilities, the majority of the sample is comprised of males (72%) with an average age of 12.4 years at entry into the program. Most are White (97%) and almost half (42%) are in the custody of their biological mother only. Over two-thirds live in poverty and 83% receive Medicaid. These youth also experience numerous child and family risk factors. About one in five has been physically abused or has runaway at least once in their lifetime. One in two youth has a parent with a history of mental illness and/or substance abuse, while one in three have witnessed family violence or have a parent who has been convicted of a crime.

Due to the nature of the project, most youth are referred to the program by either the school or mental health agency. Most youth are referred for multiple presenting problems with the most common being noncompliance (55%), hyperactive-impulsive (40%), poor peer interaction (40%), academic problems (38%), and physical aggression (37%). Given their presenting problems, it is not surprising that most carry an Axis I psychiatric diagnosis at intake of either Attention Deficit-Hyperactivity Disorder or a Disruptive Behavior Disorder (73%), and about 20% have a diagnosis of Mood Disorder. In addition to having a diagnosable mental health disorder, 42% also experience chronic physical illness, mostly asthma, allergies, and frequent or severe headaches. While almost half (44%) take medication for their emotional and behavioral symptoms, only 23% are on medication for their physical health problems upon entry into the program.

To date, 12-month follow up data have been collected for 27 cases. On average, caregivers ($n = 27$) reported receiving an average of six services at one-year follow-up, with the most commonly delivered being traditional in nature. Most (90%) reported receiving individual therapy, 92% received case management services, and 62% received medication monitoring services. Less traditional services, such as flexible funding (46%), family support (47%), and transportation assistance (28%), were received by a smaller number of families. However, the percent of families reporting receipt of innovative services increased between 6- and 12-month follow up, indicating greater reliance on innovative services over time.

Outcomes for Youth and Families (n = 27) Receiving School-Based Wraparound

Within the national evaluation, outcomes are assessed for a variety of life domains at intake into the program and every six months thereafter. In addition, due to the school-based nature of the project, a local evaluation instrument is implemented to assess teacher-report of school functioning at intake and at the end of each school year. At intake, less than half of the students (46%) had an individualized education program (IEP) in the six months prior to intake. Of those, 33% had more than one disability area noted, with the majority being an emotional or behavioral disability and/or a learning disability. Following enrollment in the program, the percent of youth identified and served in special education increased by 11%. At intake, 49% of the youth had a grade average of "C" or better.

At 12-month follow-up, this percent increased to 57%. In addition to improvements in academic performance, youth receiving school-based wraparound experienced fewer suspensions and detentions following entry into the program. Between baseline and one-year follow-up, the percent of students who were suspended decreased from 40% to 15%, and the percent of time spent in detention decreased from 49% to 28%. With respect to teacher-reported classroom behavior and peer relations following participation in the program, the greatest changes were noted in students' ability to cooperate with others, relate appropriately with peers, remain on task, participate in activities with peers, and complete classwork (see Figures 1 and 2). Teachers reported less improvement in following directions, being on time, obeying rules, and having friends.

Figure 1
Teacher-Reported Classroom Behavior (*n* = 27)

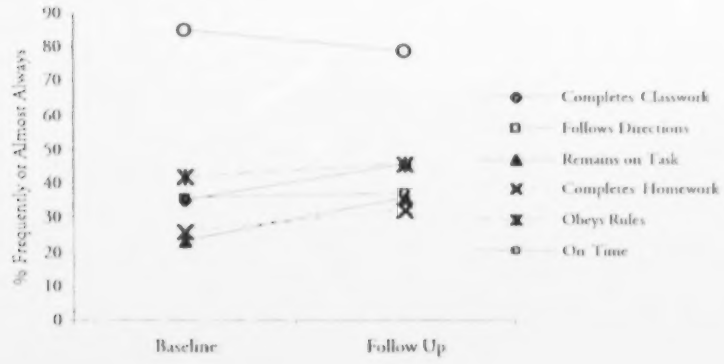
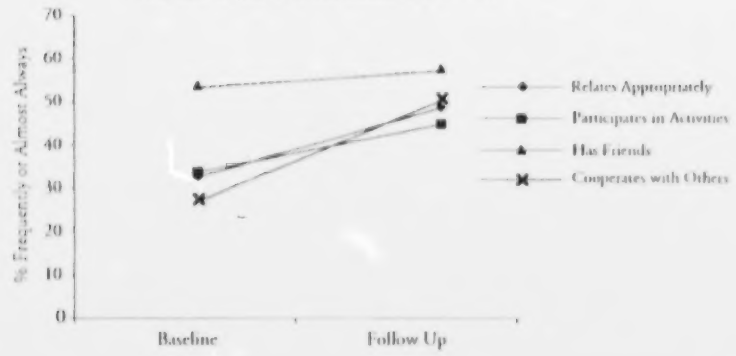


Figure 2
Teacher-Reported Peer Relations (*n* = 27)



Average problem behavior scores on the Child Behavior Checklist (CBCL; Achenbach, 1991) decreased from intake to 12 months on the Total Problem scale (with a mean score of 71 at intake and a mean score of 62, 12 months later; lower scores indicate fewer problems). Despite this decrease, the average score remained in the clinical range at one year follow up, attesting to the chronic and severe nature of the problems these youth experience. Youth functioning was measured using the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990). At intake, the average CAFAS Total Score was 104, while at 12-month follow-up the average decreased to 79. An examination of scores on the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1997) revealed an increase in the average Strength Quotient between intake (Mean: 108) and one year later (Mean: 113), indicating a slight but insignificant increase in strengths.

Discussion

Given the emerging evidence of the strong relationship between academic underachievement and mental health challenges (see, for example, Hinshaw, 1992), it seems reasonable that schools and mental health agencies should work in partnership to address the needs of this population. It has been only recently, however, that an interest in school-based services has emerged, and schools have begun to serve as the foundation for providing integrated and coordinated services (Pumariega & Vance, 1999). The results presented herein attest to the positive impact of a school-based wraparound process on the mental health *and* school functioning of youth with serious emotional and behavioral problems. Thus, it does appear that genuine partnerships among families, educators, and school-based mental health professionals does show promise as a strategy for addressing psychosocial barriers to learning.

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Discussion: PBIS for All

Marc Atkins

The papers presented in this symposium provide a behind-the-curtain view of how PBIS works to reduce disruptive behavior and increase positive behaviors in schools. The scientific basis of PBIS is illustrated by the emphasis on systemic changes that precede implementation of targeted and intensive behavioral programs, a focus on positive approaches to replace overly-punitive reactive programming, and an emphasis on systematic but practical assessment of implementation and outcomes. Using data as its ambassador, PBIS provides schools with a systematic approach to manage behavior and focus on learning. In addition, in stark contrast to the myriad of manuals and curricular that entice schools to

try one quick fix after the other, PBIS provides a guide but no blueprint, as it is the school teams who must decide and not the consultants or "coaches," to use the PBIS vernacular. This provides an exciting opportunity for mental health consultation to schools, as this flexibility can lead to a solution that may be data-based, but is not necessarily evidence-based, as, for example, the use of individual counseling for 90% of children for targeted and intensive services which is an ineffective strategy for the primary presenting problems of noncompliance and Attention Deficit Hyperactive Disorder (ADHD). The opportunity for mental health consultation is to use PBIS as a framework for effecting real changes in mental health services for students, services that support students' learning and support the key individuals, teachers and parents, who share responsibility for educating children.

CONTRIBUTING AUTHORS

Marc Atkins, Ph.D.
Professor of Psychology, Department of Psychiatry , University of Illinois at Chicago, 940 S. Wood Street, Chicago, IL 60612; 312-413-1048 fax: 312-413-4516; e-mail: Matkins@psych.uic.edu

Kari Collins, L.C.S.W.
Regional Grant Project Director, Bridges Project, Kentucky River Community Care, P.O. Box 794, Jackson, KY 41339; 606-666-9006 ext. 122, fax: 606-666-9006 ext. 115; e-mail: kecinky@hotmail.com

Laura Devine-Johnston
Special Education Supervisor, Indian-Prairie School District #204, 780 Shoreline Drive, Aurora, IL 60504; 630-375-1203, fax: 630-375-3001; email: Laura_Johnston@ipsd.org

Lucille Eber, Ed.D.
Statewide Coordinator, Illinois' EBD/PBIS Network, 160 Ridgewood Avenue, Riverside, IL 60535, 708-447-3706, fax: 708-447-5682, e-mail: LEWRAPH@aol.com

Debra Pacchiano, Ph.D.
Sub-Region Coordinator, Illinois PBIS Network, 160 Ridgewood Avenue, Riverside, IL; 708-447-3706, fax: 708-447-5682; e-mail: dpacchiano@aol.com

Teri Palmer, Ph.D.
National PBIS Center, University of Oregon, Eugene, OR 97403-5262; 541-346-3536, fax: 541-346-5689; e-mail: tlpalmer@oregon.uoregon.edu

Vestena Robbins, Ph.D.
Evaluation Coordinator, Bridges Project, REACH. of Louisville, Inc., 26 Cammack Building, Eastern Kentucky University, 521 Lancaster Ave. Richmond, KY 40475; 859-622-3045, fax: 859-622-5871; e-mail: vestena.robbins@eku.edu

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